

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## REQUEST FOR REHAB CONFERENCE

Submitted by: ☐ Claimant ☐ Employer / Insurer ☐ Supplier

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
-----------------	--------------------	---------------------	------	------------------------	----------------

### A. IDENTIFYING INFORMATION

<b>EMPLOYEE</b>	Phone Number	County of Injury	<b>EMPLOYER</b>	Name	
Address			Address		Phone Number
Employee E-mail			Employer E-mail		
<b>REHAB SUPPLIER</b>	Name		<b>INSURER / SELF-INSURER</b>	Name	
Address		Phone Number	<b>CLAIMS OFFICE</b>	Name	
		Registration Number	Address		Phone Number
Supplier E-mail			Claims E-mail		
<b>ATTORNEY FOR EMPLOYEE / CLAIMANT</b>	Name		<b>ATTORNEY FOR EMPLOYER / INSURER</b>	Name	
Address		Phone Number	Address		Phone Number
Attorney Bar Number			Attorney Bar Number		
Attorney E-mail			Attorney E-mail		

### B. ISSUES:

--

### C. CERTIFICATE OF SERVICE

<input type="checkbox"/> I certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, GA 30303-1299	
Print Name Here	Telephone Number
Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).